

**IMMUNIZATION ADMINISTRATION CHART - CHILD****Clinic Name/Address:**

NAME:					PATIENT'S SOCIAL SECURITY NO:				
BIRTHDATE: M <input type="checkbox"/> F <input type="checkbox"/>					MOTHER'S MAIDEN NAME:				
ADDRESS:					CITY:		STATE:		ZIP:
TELEPHONE NUMBER:					I.D. NUMBER:				
"I agree to allow this health care provider to release information on vaccinations given to me, or to the person for whom I am authorized to consent, to the Kansas Immunization Program, other health care providers, and schools to avoid the need for unnecessary repeat vaccinations and to provide information on what immunizations have been received. I understand I am not required to agree to the release of this information in order to receive vaccinations today."									
"I have read or had explained to me information contained in the Vaccine Information Statement (VIS) associated with any vaccines requested today. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this form be given to me or the person named on this health record for whom I am authorized to consent."									
VACCINE (CIRCLE WHAT IS GIVEN)	DATE SHOT & VIS GIVEN	SIGNATURE OF RECIPIENT OF VACCINE OR PERSON AUTHORIZED TO REQUEST	VACCINE MANUF.	VACCINE LOT NO.	EXP DATE	SITE GIVEN	NAME/TITLE OF VACCINE ADMINISTRATOR	VIS PUB DATE	VFC/ CHD CODES (below)
DTaP/DTP/DT1						LVL RVL			
DTaP/DTP/DT2						LVL RVL LD RD			
DTaP/DTP/DT3						LVL RVL LD RD			
DTaP/DTP/DT4						LD RD			
DTaP/DTP/DT5						LD RD			
Td						LD RD			
Td						LD RD			
Polio 1						LSQ RSQ ORAL			
Polio 2						LSQ RSQ ORAL			
Polio 3						ORAL LSQ RSQ			
Polio 4						ORAL LSQ RSQ			
MMR 1						LSQ RSQ			
MMR 2						LSQ RSQ			
Hib 1						LVL RVL LD RD			
Hib 2						LVL RVL LD RD			
Hib 3						LVL RVL LD RD			
Hib 4						LD RD			
Hep A 1						LD RD			
Hep A 2						LD RD			
Hep B 1						LVL RVL LD RD			
Hep B 2						LVL RVL LD RD			
Hep B 3						LVL RVL LD RD			
Varicella 1						LSQ RSQ			
Varicella 2						LSQ RSQ			
Pneumo-conj 1						LVL RVL LD RD			
Pneumo-conj 2						LVL RVL LD RD			
Pneumo-conj 3						LVL RVL LD RD			
Pneumo-conj 4						LVL RVL LD RD			
Meningo-conj						LD RD			
Influenza 1						LVL RVL LD RD			
Influenza 2						LVL RVL LD RD			
INCLUDE DATE AND PROVIDER OF PREVIOUS IMMUNIZATIONS									
TB TEST	DATE GIVEN	PROVIDER SIGNATURE	DATE READ	RESULT	VFC CODES: 1 = Medicaid, 2 = Uninsured, 3 = Native American or Alaskan Native, 4 = HealthWave, 5 = Under Insured (RHC/FQHC only)				
					CHD CODES: 6 = Under Served, 7 = Under Insured (RHC/FQHC only)				

**IMMUNIZATION ADMINISTRATION CHART - ADULT****Clinic Name/Address:**

NAME:					BIRTHDATE:					
I.D. NUMBER:		M <input type="checkbox"/> F <input type="checkbox"/>		TELEPHONE NUMBER:						
ADDRESS:				CITY:		STATE:		ZIP:		
"I agree to allow this health care provider to release information on vaccinations given to me, or to the person for whom I am authorized to consent, to the Kansas Immunization Program, other health care providers, and schools to avoid the need for unnecessary repeat vaccinations and to provide information on what immunizations have been received. I understand I am not required to agree to the release of this information in order to receive vaccinations today."										
"I have read or had explained to me information contained in the Vaccine Information Statement (VIS) associated with any vaccines requested today. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this form be given to me or the person named on this health record for whom I am authorized to consent."										
VACCINE (CIRCLE WHAT IS GIVEN)	DATE SHOT & VIS GIVEN	SIGNATURE OF RECIPIENT OF VACCINE OR PERSON AUTHORIZED TO REQUEST			VACCINE MANUF.	VACCINE LOT NO.	EXP DATE	SITE GIVEN	NAME/TITLE OF VACCINE ADMINISTRATOR	VIS PUB DATE
Td								LD RD		
Td								LD RD		
Td								LD RD		
IPV 1								LD RD		
IPV 2								LD RD		
IPV 3								LD RD		
MMR 1								LSQ RSQ		
MMR 2								LSQ RSQ		
Influenza 1								LD RD		
Influenza 2								LD RD		
Influenza 3								LD RD		
Influenza 4								LD RD		
Pneumococcal 1								SQ or IM		
Pneumococcal 2								SQ or IM		
Meningo-conj								LD RD		
Hep A 1								LD RD		
Hep A 2								LD RD		
Hep B 1								LD RD		
Hep B 2								LD RD		
Hep B 3								LD RD		
Varicella 1								LSQ RSQ		
Varicella 2								LSQ RSQ		
<b>OTHER IMMUNIZATIONS</b>										
Typhoid										
Cholera										
Yellow Fever										
Other										
TB TEST	DATE GIVEN	SIGNATURE OF PROVIDER	DATE READ	RESULT	TEST	DATE GIVEN	SIGNATURE OF PROVIDER	DATE READ	RESULT	